U.S. DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Robert W. Johnson,

Plaintiff.

V.

Erie County Medical Center Corporation, Erie County Center Program, Officer A. Shields : Badge #39, Officer Scanlon, Officer Chapman, Officer John Doe of ECMC Security, New York State, New York State Department of Health Centralized Hospital Intake Program, Medicare, Medicaid, Key Bank, New York State Department of Health : Office of Professional Medical Conduct Intake Unit Riverview Center, New York State Education Department : Office of Professional Discipline,

Defendants:
New York State Department of Health Medical Records Access Review Committee, DOH-1989, Section 18 of Public Health Law, Livanta, Title XIX of the Social Security Act, Patients Bill of Rights, Public Health Laws, Independent Professional Review Agents, Department of Health & Human Services, Public Health Laws, Quality Improvement Organization, Centers for Medicare & Medicaid Services, State Health Department, Health Care Proxy Laws, Research Statewide Planning and Cooperative System (SPARCS), SPARCS Operations: Bureau of Health Informatics: Office of Quality and Patient Safety: New York State Department of Health, New York State Domestic and Sexual Violence Hotline,

Defendants:
Kaleida Health, General Physician, PC, Olean General Hospital, Bradford Regional Medical Center, Erie County Medical Center, Dr. Hong Yu, ECMC Security Andrew, ECMC Security Suri, ECMC Security Richard, ECMC Security John Doe, Comprehensive Psychiatric Emergency Program, Crisis Services, New York State Office of Mental Health, Mental Hygiene Laws, Article 730 of the Criminal Procedure Laws, Rights of Inpatients in New York State Psychiatric Centers, Mental Health Legal Services, WNY OMH Field Office, Erie Co. Dept. of Mental Health, the NYS Commission on Quality of Care for the Mentally Disabled, William Newell, New York State Department of Justice Center,

Defendants:
Buffalo Police Officer D. Kimmins; Badge # PO 3527, Buffalo Police C District, Crisis Services Case Worker Mo, ECMC Public Safety Officers & Erie Alliance of the Mentally Ill.

Statement of Facts:
All defendants aided & abetted each other to deny Robert W. Johnson his human & civil rights for misconducts and false arrests and detained Robert W. Johnson illegally and caused Plaintiff harm.

To Whom It May Concern:

On 11/16/2022, I, Robert W. Johnson was illegally accosted and detained by Officer A. Shields: Badge #39, Officer Scanlon, Officer Chapman & Officer John Doe of ECMC Security on E. Delevan Ave and Winchester St. in Buffalo, NY 14211. Robert W. Johnson was harassed, (2) Wrist was twisted harshly and Robert W. Johnson was placed in excruciating tight handcuffs that caused bruising and pains. Robert W. Johnson was not read any Miranda or civil rights for being detained by Officer A. Shields: Badge #39, Officer Scanlon, Officer Chapman & Officer John Doe and Robert W. Johnson was not given reasons for his arrest. Robert W. Johnson was driven to ECMC CPEP: 462 Grider St. Buffalo, NY 14215 where Robert

W. Johnson was thrown to the ground face first. Robert W. Johnson was assaulted and sexually assaulted by Public Safety Officers at CPEP ECMC. Robert W. Johnson suffered chest pains, back pains, (L) Wrist, (L) Arm, (R) Wrist, (R) Arm, (L) Leg, (L) Ankle, (R) Leg, (R) Ankle, Head and Neck injuries from Public Safety Officer(s) Peter, Officer Richard, Officer Suri and Officer John Doe of ECMC Public Safety. Robert W. Johnson was then strapped to a hospital gurney and injected with a liquid substance by an ECMC staff member in which Robert W. Johnson became drowsy and weak. Robert W. Johnson was then placed in a room with another psychiatric patient.

On 11/17/2022 Robert W. Johnson was sexually assaulted by his roommate and Robert W. Johnson made reports to CPEP ECMC staff and New York State Justice Center. Robert W. Johnson called 911 over ten times and 911 did not respond in a timely manner. RN William Newell, CPEP ECMC & Operator For 911: Operator 930 failed to assist Robert W. Johnson in a timely manner. Robert W. Johnson was given a file number by New York State Department of Justice entitled 101-226998998598 for misconduct done on 11/16/2022. New York State Department of Justice forwarded Robert W. Johnson a complaint for sexual assault entitled 101-226993629 64.

Robert W. Johnson made reports to Dr. Hong Yu to be moved and released from CPEP: ECMC but was denied. Robert W. Johnson was taken to the ER at ECMC for treatment from CPEP: ECMC Public Safety Officers, Officer A. Shields and sexual assault injuries. Buffalo Police Officer D. Kimmins: Badge PO 3527 interviewed Robert W. Johnson and furnished complaint incident # 22-321078. Crisis Services was contacted and Case Worker Miss Mo interviewed Robert W. Johnson while being treated for sustained injuries. Dr. Hong Yu told Robert W. Johnson he would be released from medical hold if he took medications prescribed on 11/18/2022

and Robert W. Johnson had taken medications as ordered. Robert W. Johnson was denied release and Robert W. Johnson filed a report with New York State Dept. of Justice entitled 101-227001522228. On 11/18/2022 Robert W. Johnsan became sick from food and medications prescribed to Robert W. Johnson. On 11/19/2022 Robert W. Johnson became nauseous and began vomitting and had a near death experience twice. Robert W. Johnson called New York State Justice and made a report about poisoning experiences entitled 101-227003306634. Robert W. Johnson called 911 & ECMC ER and was denied medical treatment and New York State Dept. of Justice

filed additional complaint numbered
101-22700341271 for
misconducts on 11/19/2022.

Robert W. Johnson
Robert W. Johnson
November 19, 2022

11/16/22
M000810238
JOHNSON,ROBERT
DOB: 02/26/1984 38 SEX:M
V00007067670 ERCPEP

MENTAL HEALTH PATIENT BILL OF RIGHTS (PG 1 OF 2)

ECMC
ERIE COUNTY MEDICAL CENTER CORPORATION

This Bill of Rights pertains to the Erie County Medical Center Program consistent with Section 587.7 of the Mental Hygiene Law.

A. As a patient admitted to an outpatient program certified by the Office of Mental Health you have the right to:

1. An individual plan of treatment services and to participate to the fullest extent consistent with your capacity in the establishment and revision of that plan.

2. A full explanation of the services provided in accordance with your treatment plan.

3. Participate voluntarily in treatment in an outpatient program and consent to such treatment. The right to participate voluntarily in and to consent to treatment shall be limited only to the extent that:

   i) Receipt of outpatient services have been Court ordered;

   ii) Consent for outpatient services has been provided by a Court appointed conservator or committee on your behalf;

   iii) Consent for outpatient services has been provided by a parent or guardian of a minor; or

   iv) You engage in conduct, which poses a risk of physical harm to yourself or others.

4. Full participation and treatment as a central goal. Your objection to your treatment plan or disagreement with any portion thereof, shall not in and of itself result in your termination from the program, unless such objection renders your continued participation in the program clinically inappropriate or would endanger the safety of you or others.

5. Confidentiality of your clinical records to be maintained in accordance with Mental Hygiene Law and HIPPA. The hospital may not reveal mental health information about you to other persons outside of the hospital without your written authorization, except in the following situations:
   - When the hospital has obtained your written authorization
   - To a personal representative who is authorized to make health care decisions on your behalf
   - To government agencies or private insurance companies in order to obtain payment for services we provided to you
   - To comply with a court order
   - To appropriate persons who are able to avert a serious and imminent threat to the health or safety of you or another person
   - To appropriate government authorities to locate a missing person or conduct a criminal investigation as permitted under Federal and State confidentiality laws
   - To other licensed hospital emergency services is permitted for the purpose of procuring treatment, payment or other health care operations.
   - To the mental hygiene legal service offered by the State
   - To attorneys representing patients in an involuntary hospitalization proceeding
   - To authorized government officials for the purpose of monitoring or evaluating the quality of care provided by the hospital or its staff
   - To qualified researchers with your specific authorization.
   - To coroners and medical examiners to determine cause of death

MENTAL HEALTH PATIENT BILL OF RIGHTS (PG 2 OF 2)

6. You have access to your clinical record except when this access is determined to possibly cause imminent or serious harm to you or others. If access is denied you may appeal to the Regional Office of Mental Health.

7. Receive clinically appropriate care and treatment that is suited to your needs, and skillfully, safely and humanely administered with full respect for your dignity and personal integrity.

8. Receive services in such a manner as to assure nondiscrimination.

9. Treatment in a way that acknowledges and respects your cultural environment.

10. A maximum amount of privacy consistent with effective delivery of services.

11. Freedom from abuse and mistreatment by employees.

12. Information regarding the Hospital s Patient Grievance Policies and Procedures and to initiate any question, complaint or objection accordingly.

B. In the event that you have any questions, concerns or issues relative to your care and treatment at the Erie County Medical Center, you may contact the Outpatient Program Supervisor 898-5569, or Hospital Administration at 898-3955, or any of the following:

1. The NYS Commission on Quality of Care for the Mentally Disabled
401 State Street
Schnectady, New York 12305-2397
(518) 381-7102

2. Mental Health Association of Erie Co. Inc.
Client Advocacy Program
999 Delaware Avenue
Buffalo, NY 14209
(716) 886-1242

3. Mental Hygiene Legal Services
2180 Elmwood Avenue
Buffalo, NY 14216
(716) 874-7532

4. Erie Alliance of the Mentally Ill
264 Hamilton Drive
Snyder, NY 14226
(716) 839-0548

5. Erie Co. Dept of Mental Health
95 Franklin Street
Buffalo, NY 14202
(716) 858-9530

6. WNY OMH Field Office
737 Delaware Avenue, Suite 200
Buffalo, NY 14209
(716) 885-4219

7. Division of Alcoholism & Alcohol Use
Regional Office
1021 Main Street
Buffalo, NY 14203
(716) 885-0701

Patients' Bill of Rights

As a patient in a hospital in New York State, you have the right, consistent with law, to:

(1) Understand and use these rights. If for any reason you do not understand or you need help, the hospital MUST provide assistance, including an interpreter.
(2) Receive treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation, gender identity or expression, physical appearance, source of payment or age.
(3) Receive considerate and respectful care in a clean and safe environment free of unnecessary restraints.
(4) Receive emergency care if you need it.
(5) Be informed of the name and position of the doctor who will be in charge of your care in the hospital.
(6) Know the names, positions and functions of any hospital staff involved in your care and refuse their treatment, examination or observation.
(7) A no smoking room.
(8) Receive complete information about your diagnosis, treatment and prognosis.
(9) Receive all the information that you need to give informed consent for any proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment.
(10) Receive all the information you need to give informed consent for an order not to resuscitate. You also have the right to designate an individual to give this consent for you if you are too ill to do so. If you would like additional information, please ask for a copy of the pamphlet "Deciding About Health Care -- A Guide for Patients and Families."
(11) Refuse treatment and be told what effect this may have on your health.
(12) Refuse to take part in research. In deciding whether or not to participate, you have the right to a full explanation.
(13) Privacy while in the hospital and confidentiality of all information and records regarding your care.
(14) Participate in all decisions about your treatment and discharge from the hospital. The hospital must provide you with a written discharge plan and written description of how you can appeal your discharge.
(15) Review your medical record without charge. Obtain a copy of your medical record for which the hospital can charge a reasonable fee. You cannot be denied a copy solely because you cannot afford to pay.
(16) Receive an itemized bill and explanation of all charges.
(17) Complain without fear of reprisals about the care and services you are receiving and to have the hospital respond to you and if you request it, a written response. If you are not satisfied with the hospital's response, you can complain to the New York State Health Department. The hospital must provide you with the State Health Department telephone number.
(18) Authorize those family members and other adults who will be given priority to visit consistent with your ability to receive visitors.
(19) Make known your wishes in regard to anatomical gifts. You may document your wishes in your health care proxy or on a donor card, available from the hospital.

Public Health Law(PHL)2803 (1)(g)Patient's Rights, 10NYCRR, 405.7,405.7(a)(1),405.7(c)

Declaración de derechos de los pacientes

Como paciente de un hospital del estado de Nueva York, usted tiene el derecho, según la ley, a:

(1) Comprender y utilizar estos derechos. Si por alguna razón, usted no entiende o necesita ayuda, el hospital DEBE ayudarlo, incluso brindarle los servicios de un intérprete.

(2) Recibir tratamiento sin discriminación de raza, color, religión, sexo, origen, discapacidad, orientación sexual, fuente de pago, o la edad.

(3) Recibir atención considerada y respetuosa en un ambiente limpio y seguro sin que haya limitaciones innecesarias.

(4) Recibir atención médica de emergencia si lo necesita.

(5) Que se le informe el nombre y el cargo del doctor que lo va a atender en el hospital.

(6) Saber los nombres, cargos y funciones de todo el personal hospitalario que participe de su cuidado y rehusarse a recibir su tratamiento, exámenes u observación.

(7) Tener una habitación para no fumadores.

(8) Recibir información completa sobre su diagnóstico, tratamiento y prognosis.

(9) Recibir toda la información que necesita para dar consentimiento informado para la realización de un procedimiento o tratamiento. Esta información debe contener los riesgos posibles y beneficios del procedimiento o tratamiento.

(10) Recibir toda la información que necesita para dar consentimiento informado para dar instrucciones de no resucitarlo. Usted también tiene el derecho de designar a una persona para que de el consentimiento por usted en caso de que se encuentre demasiado enfermo para hacerlo. Si le gustaría recibir más información, por favor, solicite una copia del folleto "Pedido de no resucitar— Guía para pacientes y familias".

(11) Rechazar tratamiento y que se le informe cuál es el efecto que este puede tener en su salud.

(12) Rechazar ser parte de un estudio de investigación. Al decidir si quiere participar o no, usted tiene el derecho de que se le de toda la información disponible.

(13) Tener privacidad mientras se encuentra en el hospital y confidencialidad de toda la información y de los expedientes relacionados con su caso.

(14) Participar en todas las decisiones acerca de su tratamiento y alta del hospital. El hospital debe suministrarle por escrito un plan de alta y una descripción de cómo apelar su alta.

(15) Revisar su historia clínica sin cargo alguno. Obtener una copia de su historia clínica por la cual el hospitla puede cobrarle un precio razonable. A usted no se le puede denegar una copia solamente porque no puede pagarla.

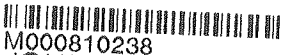
(16) Recibir una factura desglosada y una explicación de todos los cargos.

(17) Quejarse sin tener miedo a represalias acerca del cuidado y servicios que está recibiendo y hacer que el hospital le responda, y si es que así usted lo solicita, una respuesta por escrito. Si usted no está satisfecho con la respuesta del hospital, puede quejarse al Departamento de Salud del estado de Nueva York. El hospital debe suministrarle el número de teléfono del Departamento de Salud del estado.

(18) Autorizar a los miembros de su familia y a otros adultos a los que se les dará prioridad de visita conforme usted tenga la capacidad de recibir visitas.

(19) Hacer conocer sus deseos con relación a lo que quiere hacer con sus órganos. Usted puede documentar sus deseos en su poder para la atención médica en una tarjeta de donante que se encuentra disponible en el hospital.

Ley de Salud Pública(PHL)2803 (1)(g)Derechos de los pacientes, 10NYCRR, 405.7,405.7(a)(1),405.7(c)



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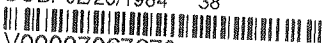

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AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

ECMC
Erie County Medical Center Corporation

Patient Name	Date of Birth	Patient Identification Number/Social Security Number

Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDSRELATED INFORMATION, except psychotherapy notes, only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be redisclosed by the recipient. If I am authorizing the release of HIV/AIDS related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I also understand that any disclosure/ release is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of alcohol and drug abuse patient records, as well as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 &164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. If I experience discrimination because of the release or disclosure of HIV/AIDS related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
☑ **Erie County Medical Center Corporation/Terrace View 462 Grider St., Buffalo NY 14215;** ☐ **Adult, Child & Family clinic 462 Grider St., Buffalo, NY 14215** ☐ **Depew Clinic 5089 Broadway, Depew NY 14043** ☐ **Downtown Clinic 1285 Main St. 2nd Floor, Buffalo NY14209** ☐ **Downtown Clinic 1285 Main St. 1st Floor, Buffalo, NY 14209** ☐ **Northern Erie Clinical Services, 2005 Sheridan Drive, Buffalo, NY 14223** ☐ **Center for Bariatric & Metabolic Surgery 30 North Union Rd. Suite 104 Williamsville, NY 14221**

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Carol (mother) 716-253-3577 (cell)

7. Purpose for Release of Information: Coordination of care

8. Specific information to be released:
☐ Medical Record from (insert date)_____ to (insert date)_____
☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, and consults.
☐ Other:_____ Include: *(Indicate by Initialing)*
_____ Alcohol/Drug Treatment
_____ *Mental Health Information
_____ HIV-Related Information

9. This consent shall expire six (6) months from its signing, unless a different time period, event or condition date is specified here:

10. If not the patient, name of person signing form:

11. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.
* If this request is being completed as a walk-in/in person, I have been educated by the HIM staff to what records I will be receiving today at ECMCC. If I need more than what is part of the abridged copy I have requested then those records will be sent to me following the HIPAA regulation for a release of information.
Indicate by Initialing: Abridged copy satisfactory: _____ Additional record needed/new form completed:_____

Signature of patient or presentative authorized by law — Date: 11/18/2022

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative if filled out at facility.

Signature of witness — Date: 11/18/22

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Robert Johnson	2/26/1994	N/A

Patient Address: 65 Sidney St, Buffalo, NY 14211

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
ECMC Yow Center

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Crisis Services Advocate Department 100 River Rock Drive Suite 300 Buffalo, NY 14207

7. Purpose for Release of Information:
Case coordination

8. Unless previously revoked by me, the specific information below may be disclosed from: 11/17/22 (INSERT START DATE) until 5/17/23 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except: N/A

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Robert N Johnson — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

11/17/2022 — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE | SIGNATURE | DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Robert Johnson	2/26/1984	N/A

Patient Address: 65 Sidney St, Buffalo, NY 14211

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Buffalo Police Dept

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Crisis Services Advocate Department 100 River Rock Drive Suite 300 Buffalo, NY 14207

7. Purpose for Release of Information:
Case coordination related to criminal investigation

8. Unless previously revoked by me, the specific information below may be disclosed from: 11/17/22 (INSERT START DATE) until 5/17/23 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except: N/A

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Robert W. Johnson — 11/17/2022
SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Robert Johnson	2/26/1984	N/A

Patient Address: 65 Sidney St, Buffalo, NY 14211

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
BRAVE Program at ECMC 462 Grider Street Buffalo, NY 14215

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Crisis Services Advocate Department 100 River Rock Drive Suite 300 Buffalo, NY 14207

7. Purpose for Release of Information:
Case coordination

8. Unless previously revoked by me, the specific information below may be disclosed from: 11/17/22 (INSERT START DATE) until 5/17/23 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except: N/A

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Robert W. Johnson — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW — DATE 11/17/2022

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE — SIGNATURE — DATE / /

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NEW YORK STATE DEPARTMENT OF HEALTH

Authorization for Release of Health Information (Including Alcohol/Drug Treatment and Mental Health Information) and Confidential HIV/AIDS-related Information

Patient Name	Date of Birth	Patient Identification Number
Robert Johnson	2/26/1984	N/A

Patient Address: 65 Sidney St, Buffalo, NY 14211

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

1. This authorization may include disclosure of information relating to ALCOHOL and DRUG TREATMENT, MENTAL HEALTH TREATMENT, and CONFIDENTIAL HIV/AIDS-RELATED INFORMATION only if I place my initials on the appropriate line in item 8. In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 8, I specifically authorize release of such information to the person(s) indicated in Item 6.
2. With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. If I experience discrimination because of the release or disclosure of HIV/AIDS-related information, I may contact the New York State Division of Human Rights at 1-888-392-3644. This agency is responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the provider listed below in Item 5. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. I understand that generally my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

5. Name and Address of Provider or Entity to Release this Information:
Erie County District Attorney's Office 25 Delaware Ave Buffalo, NY 14202

6. Name and Address of Person(s) to Whom this Information Will Be Disclosed:
Crisis Services Advocate Department 100 River Rock Drive Suite 300 Buffalo, NY 14207

7. Purpose for Release of Information:
Case coordination related to criminal court

8. Unless previously revoked by me, the specific information below may be disclosed from: 11/17/22 (INSERT START DATE) until 5/17/23 (INSERT EXPIRATION DATE OR EVENT)

☐ All health information (written and oral), except: N/A

For the following to be included, indicate the specific information to be disclosed and initial below.	Information to be Disclosed	Initials
☐ Records from alcohol/drug treatment programs		
☐ Clinical records from mental health programs*		
☐ HIV/AIDS-related Information		

9. If not the patient, name of person signing form:

10. Authority to sign on behalf of patient:

All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of the form.

Robert W. Johnson — SIGNATURE OF PATIENT OR REPRESENTATIVE AUTHORIZED BY LAW

11/17/2022 — DATE

Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's authorized representative.

STAFF PERSON'S NAME AND TITLE | SIGNATURE | DATE

This form may be used in place of DOH-2557 and has been approved by the NYS Office of Mental Health and NYS Office of Alcoholism and Substance Abuse Services to permit release of health information. However, this form does not require health care providers to release health information. Alcohol/drug treatment-related information or confidential HIV-related information released through this form must be accompanied by the required statements regarding prohibition of re-disclosure.

*Note: Information from mental health clinical records may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

DOH-5032 (4/11)

Erie County Medical Center
Immunodeficiency Services

Emergency Room Visit Follow-Up

Today you decided to begin taking **PEP (Post Exposure Prophylaxis)**, medications to reduce the risk of HIV (Human Immunodeficiency Virus) infection after a possible exposure. The risk of transmission is low and may vary depending upon your exposure. Below are recommendations for you to follow to ensure that you are receiving the best possible care.

NYS DOH Guidelines recommend that these medications be taken for 28 days. You have been given a 7 day supply of PEP today and a prescription for an additional 21 days.

- You are taking Truvada, a pill once each day and Isentress, pill one in the morning and one at night
- Try to take the medications at the same time each day, many people find it helpful to take them with breakfast and at bedtime. If you experience flu-like symptoms, fever, sore throat or a body rash, please call 716-898-4713 and you will be seen by our HIV specialist as soon as possible
- Some people may have side effects from the medications such as nausea, diarrhea and fatigue and some don't experience any. If you are experiencing side effects there are medications that can be ordered to help relieve these symptoms. It will also help to take these medications with some food such as crackers or toast
- Not all pharmacies carry these medications so it is important that you have the prescriptions filled before you run out. The pharmacy may dispense more than a 21 day supply but you will only need to take these medications for 28 days. You may call the numbers below for a list of pharmacies that will always have these medications in stock.
- PEP recommendations also include a monitoring process that includes a visit in two weeks with a clinician and blood work. The clinicians in Immunodeficiency Services are specially trained and available to provide this service for you. If you would prefer to follow-up with you primary care provider we are available for consultation if needed.

It is important that you do not stop taking your medications before speaking with a clinician in Immunodeficiency Services, 716-898-4713 or 716-898-4119.

Contact a clinician at 716-898-4713 or 716-898-4119 if you have any problems taking the medications, getting your prescription filled, experience flu-like symptoms or to schedule a follow-up appointment. The Clinic is open Monday-Friday between the hours of 8:00-4:00pm and is located in the lower level, "Tunnel" of the hospital.

We are here to help you in any way we can, you are not alone!

8.2019

Reliefs Requested:

$100,000,000.00 for punitive damages: 100% Ownership of Defendants Corporations: $1,000,000,000.00 Administrative Sanctions: All other Reliefs Just & Proper.

Robert W. Johnson
Robert W. Johnson

11/19/2022

In Forma Pauperis Affidavit

My name is Robert W. Johnson and I am requesting Leave To Proceed as a Poor Person For Attached hereto matters. Robert W. Johnson is a Poor Person and has no form of income, assets, upcoming monetary or property awards and requests Courts To Grant Court Litigations.

Robert W Johnson 11/19/2022

Robert W. Johnson

CERTIFICATE OF SERVICE

I, Robert W. Johnson, served a copy of Civil Complaint & In Forma Pauperis Affidavit on 11/19/2022 upon the following via U.S. Mail:

1. Court Clerk: 500 Pearl St.: New York, NY 10007.

2. NYS Dept. of Health
Empire State Plaza
Albany, NY 12237.

Robert W Johnson 11/19/2022
Robert W. Johnson

ROBERT W. JOHNSON
112 COURT ST. APT. 2
WATERTOWN, NY 13601

COURT CLERK
U.S. COURTHOUSE : 500 PEARL ST
NEW YORK, NY 10007

Pro se

UNITED STATES POSTAL SERVICE

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FCM LETTER
BUFFALO, NY
14240
NOV 25, 22
AMOUNT
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S.D.N.Y.